Construction - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date: / /	Legal Name:	Application ID:

Application completed by: Broker: ☐ Employer: ☐

Please provide (*first, last)* name: ______________________________ Date: ______________________________

Indicate percentage of work conducted in each of the following:

Commercial:____% Residential: ____% **= 100%**

Interior: ____% Exterior: ____% **= 100%**

New construction: ____% Remodeling/Service/Repair: ____% **= 100%**

Percentage of jobs with roof top exposure:_____% ☐N/A

24/7 service? Yes ☐ No ☐

Any use of cranes, booms, or similar heavy construction equipment? Yes ☐ No ☐

Percentage of work sub-contracted out: _________%

Please explain the type of work sub-contracted out:

[text here]

Are certificates collected annually for sub-contractors?
Yes ☐ No ☐

Any work with asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement?
Yes ☐No ☐ If yes, please provide details:

Any interchange of labor? Yes ☐No ☐If yes, please explain:

CSLB Qualifiers Name: ______________________________________ Classification assigned: ________________ Payroll: $______________

Please provide a brief description of the qualifier's duties: ____

General Classification Evaluation:

1) Maximum Height exposure: _____Ft. ☐N/A

   If applicable - Method of reaching height exposures: (*Check all that apply)*
   Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ Other: ☐ __________

   If scaffolding is used, does the insured build their own? No ☐Yes - _____% of annual operations compared to total operations.

2) Maximum Weight lifted: _____lbs. ☐N/A

   If applicable: Manual Lifting ☐ Employee(s) lifts with assistance: ☐ Please explain: _____________________
   Please list the typical types of items lifted: ____

3) Vehicle exposure: No ☐ Yes ☐

   If Yes –
   Percentage of total operations: _____% Total # of Vehicles_____
   Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes ☐ No ☐
   Driving Radius in miles: _____mi. GPS tracking system installed? Yes ☐ No ☐
   MVR's Checked: Yes ☐ No ☐ Company Owned: Yes ☐ No ☐
   PUC Filing: N/A ☐Yes: __________ MCP Filing: N/A ☐Yes: __________

4) Any Out of State, International, or Overnight Travel: Yes ☐ No ☐

   If Yes - Please provide:
   Number of employees traveling: ____
   Method of transportation: __________________ Location(s): ________________________________
   Frequency of travel: _______________________ ________________________________

5) CPR Training provided: Yes ☐ No ☐ **If Yes -** Number of Employees certified: _____

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Claims Handling:

1) Is there a set procedure for reporting claims? Yes ☐ No ☐
2) Is there a formal written accident investigation report? Yes ☐ No ☐
3) Do you currently participate in an MPN program to control claim costs? Yes ☐ No ☐

Personnel Practices:

1) New-hire orientation program: Yes ☐ No ☐ Is the orientation documented? Yes ☐ No ☐
2) Owner is active in daily operations: Yes ☐ No ☐
3) Employee Handbook: Yes ☐ No ☐
4) Post-accident drug testing: Yes ☐ No ☐
5) Job specific training: Yes ☐ No ☐
6) Performance Appraisals: Yes ☐ No ☐
7) Wellness program in place: Yes ☐ No ☐
8) Are any of the following benefits provided?
   Medical: No ☐ Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
   Retirement: No ☐ Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
9) Any other information in regard to employee benefits? If so, please provide those details:
   ____

Employer-Employee Relationship:

1) Employee Turnover Rate (Annually): ____% Average Tenure of Employees (in # of years): _______
2) Number of employees hired:
   Full Time (annual): ____ Payroll Estimate: $_______
   Part Time/Seasonal: ____ Payroll Estimate: $_______
   No. of seasonal Employees: _____ Seasonal Employee Period (From Month: _________ to Month: ________)

Safety Program/Practices which are implemented and enforced:

1) Fall Protection Plan: Yes ☐ No ☐ N/A ☐
2) Heat and illness prevention program: Yes ☐ No ☐ N/A ☐
3) Respiratory program: Yes ☐ No ☐ N/A ☐
4) Driver safety training plan: Yes ☐ No ☐ N/A ☐
5) Forklift training & safety plan: Yes ☐ No ☐ N/A ☐
   If Yes – Annual Certification required: Yes ☐ No ☐ N/A ☐
6) MSDS available for all chemicals/products used: Yes ☐ No ☐ N/A ☐
7) Written Lockout/Tag out/Block out Procedures: Yes ☐ No ☐ N/A ☐
8) Hazardous chemicals safety plan: Yes ☐ No ☐ N/A ☐
9) Confined spaces plan: Yes ☐ No ☐ N/A ☐
10) Active safety incentive program for all employees: Yes ☐ No ☐ N/A ☐
11) Are supervisors held accountable for a safe work environment? Yes ☐ No ☐ N/A ☐
12) Extreme temperature program meets Cal OSHA Requirements: Yes ☐ No ☐ N/A ☐
13) Is there a dedicated full time safety manager? Yes ☐ No ☐ N/A ☐
    If Yes – Please provide:
    Name: ______________________________ Title: ______________________________
14) Safety meetings are conducted: ☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Does not conduct Safety Meetings
    Are safety meetings documented? Yes ☐ No ☐
15) Personal Protective equipment provided to all employees: No ☐ Yes, please list types:
    ____
16) Employee to Supervisor ratio: _____ / _____
17) What loss prevention recommendations has the insured implemented? ☐Loss control service has not been performed.

    Year implemented: __________
    [Text here]

Machinery and Equipment:

1) Please list the types of machinery/equipment used: ____ N/A ☐
2) Are all equipment operators certified? Yes ☐ No ☐
3) Is all machinery/equipment properly guarded: Yes ☐ No ☐
4) Age of equipment in years: ☐0-5 ☐5-10 ☐10-20 ☐20+
5) Condition of the equipment: ☐Excellent ☐Good ☐Average ☐Poor
6) Who is responsible for maintaining machinery? ☐Insured ☐Contractor ☐ Other: ________________________

Is there any other information about your company, operations, or practices you have implemented which could have an impact on mitigating injuries? *[Text here]*

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